

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015396

STATE FILE NUMBER

2 3943

Registration District No. Primary Registration District No.

Registration No.

5. 300
1-57
3
193
0

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY St. Louis Co.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Marys Infirmary		d. STREET ADDRESS 4269a Kennerley Ave	
3. NAME OF DECEASED (Type or print) First OBIE Middle MARSHALL Last		4. DATE OF DEATH April 19 1959	
5. SEX Male	6. COLOR OR RACE Col	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 12 1905
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman		9b. AGE (In years last birthday) 53	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Jackson Tenn	
13a. FATHER'S NAME Elmore Marshall		14. NAME OF HUSBAND OR WIFE Mamie Marshall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 489-16-5169	
17. INFORMANT Address Mamie Marshall 4269a Kennerley Ave		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bacterial Peritonitis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Post-op Gastrectomy DUE TO (c) Bleeding Duodenal Ulcer	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 541.0	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Death occurred at 3-25-59 to 4-19-59 and last saw him alive on 4-19-59 on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) Caedwell J. Hoffmann	
22b. ADDRESS 2616 N. Kingshighway Blvd		22c. DATE SIGNED April 29, 1959	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 4-23-1959	23c. NAME OF CEMETERY OR CREMATORY Washington Park	23d. LOCATION (City, town, or county) St. Louis Co., Mo
24. FUNERAL DIRECTOR ADDRESS Jas H. Randle & Son 3133 Bell Ave		25. DATE RECD. BY LOCAL REG. APR 21 '59	
26. REGISTRAR'S SIGNATURE Earl Smith. M.D.		27. m JB	

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Ethel K. Harris*

Licensed Embalmer No. *4458*
P. O. Address *4181 Washin*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.